#### 38-71-46 Diabetes Mellitus Coverage; Diabetes Education

- (A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for the treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.
- (B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.
- (C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.
- (D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

#### 38-71-125 Mastectomies; hospitalization requirements; early release provisions

All individual and group health insurance policies and health maintenance organizations providing coverage for the hospitalization for mastectomies must provide benefits for hospitalization for at least forty-eight hours following a mastectomy. Nothing in this section shall be construed to prohibit an attending physician from releasing the patient prior to the

expiration of the time provided herein. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending physician.

## 38-71-130 Breast reconstruction and prosthetic devices; coverage following mastectomy surgery.

All individual and group health insurance policies and health maintenance organizations providing coverage for mastectomy surgery must provide coverage for prosthetic devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non-diseased breast, if determined medically necessary by the patient's attending physician with the approval of the insurer or HMO. The provisions of this section shall not require supplemental health insurance policies to provide coverage for reconstruction of the non-diseased breast.

### 38-71-135 Minimum postpartum hospitalization and attendant services for mothers and newborns.

All individual and group health insurance and health maintenance organization policies providing coverage for the hospitalization and attendant professional services of a mother and her newborn child or children must provide for the mother and her newborn child or children to remain in the hospital for at least forty-eight hours after a vaginal delivery, not including the day of delivery, and at least ninety-six hours following a Cesarean Section, not including the day of surgery. Nothing in this section shall be construed to prohibit the attending physician, in consultation with the mother, from requesting additional time for hospitalization or from releasing the mother or her newborn child or children prior to the expiration of time provided herein.

#### 38-71-140 Coverage of newborn children.

- (A) All individual and group health insurance policies providing coverage on an expense-incurred basis and individual and group service or indemnity-type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber, as to the family member's coverage, also must provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber from the moment of birth.
- (B) The coverage for a newly born child consists of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

- (C) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.
- (D)(1) The provisions of this section apply to a child with respect to whom a decree of adoption by the insured or subscriber has been entered within thirty-one days after the date of his birth and to a child with respect to whom:
- (a) Adoption proceedings have been instituted by the insured or subscriber within thirty-one days after the date of his birth and the insured or subscriber has temporary custody pursuant to Section 63-9-510;
- (b) The adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child pursuant to Section 63-9-750.
- (2) Coverage must be provided as long as the insured or subscriber has custody of the child pursuant to decree of the court and the required premiums or fees are furnished to the insurer or nonprofit service or indemnity corporation.

#### 38-71-143 Health plans must provide same coverage for children placed for adoption.

- (A) If an individual or group health plan provides coverage for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.
- (B) A group health plan may not restrict coverage under the plan of a dependent child adopted by a participant or beneficiary or placed with a participant or beneficiary for adoption solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

#### (C) For the purposes of this section:

(1) "child" means, in connection with an adoption or placement for adoption of the child, an individual who has not attained age eighteen as of the date of the adoption or placement for adoption;

(2) "placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of the legal obligations.

## 38-71-145 Required coverage for mammograms, pap smears, and prostate cancer examinations; limitations.

- (A) All individual and group health insurance and health maintenance organization policies in this State shall include coverage in the policy for:
  - (1) mammograms;
  - (2) annual pap smears;
- (3) prostate cancer examinations, screenings, and laboratory work for diagnostic purposes in accordance with the most recent published guidelines of the American Cancer Society.
- (B) The coverage required to be offered under subsection (A) may not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to that coverage unless these provisions apply generally to other similar benefits provided and paid for under the health insurance policy.
- (C) Nothing in this section prohibits a health insurance policy from providing benefits greater than those required to be offered by subsections (A) and (B) or more favorable to the enrollee than those required to be offered by subsections (A) and (B).
- (D) This section applies to individual and group health insurance policies issued by a fraternal benefit society, an insurer, a health maintenance organization, or any similar entity, except as exempted by ERISA.
  - (E) For purposes of this section:
- (1) "Mammogram" means a radiological examination of the breast for purposes of detecting breast cancer when performed as a result of a physician referral or by a health testing service which utilizes radiological equipment approved by the Department of Health and Environmental Control, which examination may be made with the following minimum frequency:
- (a) once as a base-line mammogram for a female who is at least thirty-five years of age but less than forty years of age;
- (b) once every two years for a female who is at least forty years of age but less than fifty years of age;

- (c) once a year for a female who is at least fifty years of age; or
- (d) in accordance with the most recent published guidelines of the American Cancer Society.
- (2) "Pap smear" means an examination of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the recommendation of a medical doctor, which examination may be made once a year or more often if recommended by a medical doctor.
- (3) "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

## 38-71-200 Discrimination forbidden; benefits for services of podiatrist, oral surgeon, or optometrist.

Discrimination between individuals of the same class in the amount of premiums or rates charged for a policy of insurance covered by this chapter, in the benefits payable on the policy, in terms or conditions of the policy, or in another manner is prohibited except as provided in Sections 38-57-140 and 38-71-1110. If a policy of insurance governed by this chapter provides for payment or reimbursement for a service which is within the scope of practice of a licensed podiatrist, licensed oral surgeon, licensed optometrist, or licensed doctoral psychologist, the insured or other person entitled to benefits under the policy is entitled to payment or reimbursement in accordance with the usual and customary fee for the services whether the services are performed by a licensed physician or a licensed podiatrist, a licensed oral surgeon, a licensed optometrist, or a licensed doctoral psychologist, notwithstanding a provision in the policy, and the policyholder, insured, or beneficiary may choose the provider of the services.

#### 38-71-210 Health insurance policies to include chiropractic services

If an insurer offers a policy containing a provision for medical expense benefits that does not provide payment for chiropractic services, it shall offer as a part thereof an optional rider or endorsement, if specifically requested by the insured or subscriber under an individual policy or a certificate holder or subscriber under a master policy, which defines such benefits as including payment to a chiropractor for procedures specified in the policy which are within the scope of the practice of chiropractic. Any additional cost to the insured or certificate holder must be reasonably related to benefits provided.

#### 38-71-215 **Dermatology referrals.**

- (A) If a primary care physician makes a referral to a dermatologist, the enrollee in a managed care plan may see the in-network dermatologist to whom the enrollee is referred, without further referral, for a minimum of six months or four visits, whichever first occurs, for diagnosis, medical treatment, or surgical procedures for the referral problem or related complications.
- (B) Written communication from the dermatologist should be sent to the primary care physician after each visit.
- (C) An enrollee with a documented past history of malignant melanoma may be referred by his or her primary care physician to an in-network dermatologist for an annual evaluation and, as necessary, biopsy or surgery, or both.
- (D) All services provided pursuant to this section are subject to contractual provisions regarding medical necessity and benefit coverage.
- (E) Nothing in this section may be construed to extend benefits to an enrollee past the contract period.

#### 38-71-240 Coverage required for cleft lip and palate; certain policies exempt.

- (A) As used in this section:
  - (1) "Cleft lip and palate" means a congenital cleft in the lip or palate, or both.
  - (2) "Medically necessary care and treatment" shall include, but not be limited to:
- (a) oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate;
  - (b) prosthetic treatment such as obdurators, speech appliances, and feeding appliances;
  - (c) medically necessary orthodontic treatment and management;
  - (d) medically necessary prosthodontic treatment and management;
  - (e) otolaryngology treatment and management;
- (f) audiological assessment, treatment, and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices; and
  - (g) medically necessary physical therapy assessment and treatment.
- (B)(1) Any individual or group accident and health policy which provides dependent coverage shall provide coverage for the medically necessary care and treatment of cleft lip and palate and

any condition or illness which is related to or developed as a result of a cleft lip and palate. Such a policy may contain the same copayment provisions for the coverage of cleft lip and palate as apply to other conditions or procedures covered by the policy.

- (2) Any individual or group dental policy which provides dependent coverage shall provide coverage for teeth capping, prosthodontics, and orthodontics necessary for the care and treatment of cleft lip and palate. Such a policy may contain the same copayment provisions for the coverage of cleft lip and palate as apply to other conditions or procedures covered by the policy.
- (C) If a person with a cleft lip and palate is covered by an accident and health policy described in subsection (B)(1) and is also covered by a dental policy described in subsection (B)(2), teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided and any excess thereafter shall be provided by the individual or group accident and health policy.
- (D) The provisions of this section do not apply to a policy which provides disability or income protection coverage, hospital confinement indemnity coverage, accident only coverage, specified disease or specified accident coverage, long-term care coverage, vision only coverage, or coverage issued as a supplement to Medicare.

### 38-71-245 Prohibited grounds for denial of enrollment to child of health plan participant.

No health insurer, including a group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, may deny enrollment of a child under the health plan of the child's parent on the grounds that the child:

- (1) was born out of wedlock;
- (2) is not claimed as a dependent on the parent's federal tax return; or
- (3) does not reside with the parent or in the insurer's service area.

### 38-71-250 Duties of insurer as to court-ordered health care coverage for child of eligible parent.

If, pursuant to a court order which meets the specifications of Section 63-17-2110, a parent is required to provide health coverage for a child and the parent is eligible for family health coverage through a health insurer, including a group health plan as defined in Section 607(1) of

the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, the insurer shall:

- (1) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;
- (2) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of:
  - (a) the child's other parent;
  - (b) the state agency administering the Medicaid program; or
- (c) the state agency administering 42 U.S.C. Sections 651 to 669, the child support enforcement program; and
- (3) continue coverage of the child unless the insurer is provided satisfactory written evidence that the:
  - (a) court order is no longer in effect;
- (b) child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; or
  - (c) employer has eliminated family health coverage for all of its employees.

### 38-71-275 Insurance coverage for certain drugs not to be excluded from policy definitions.

- (A) No insurance policy which provides coverage for drugs shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the drug has not been approved by the Federal Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed; provided, that such drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.
  - (B) This section shall not be construed to:
- (1) alter existing law with regard to provisions limiting the coverage of drugs that have not been approved by the Federal Food and Drug Administration;

- (2) require coverage for any drug when the Federal Food and Drug Administration has determined its use to be contraindicated;
- (3) require coverage for experimental drugs not otherwise approved for any indication by the Federal Food and Drug Administration;
- (4) create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.
  - (C) For purposes of this section:
- (1) "Insurance policy" means an individual, group, or blanket policy written by a medical expense indemnity corporation, a hospital service corporation, a health care service plan contract, or a private insurance plan issued, amended, delivered, or renewed in this State or which provides insurance for residents of this State.
  - (2) "Standard reference compendia" means:
    - (a) the United States Pharmacopoeia Drug Information;
    - (b) the American Medical Association Drug Evaluations; or
    - (c) the American Hospital Formulary Service Drug Information.
- (3) "Medical literature" means two articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer-reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed.

#### 38-71-280 Autism spectrum disorder; coverage; eligibility for benefits.

#### (A) As used in this section:

- (1) "Autism spectrum disorder" means one of the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:
  - (a) Autistic Disorder;
  - (b) Asperger's Syndrome;
  - (c) Pervasive Developmental Disorder--Not Otherwise Specified.

- (2) "Insurer" means an insurance company, a health maintenance organization, and any other entity providing health insurance coverage, as defined in Section 38-71-670(6), which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.
- (3) "Health maintenance organization" means an organization as defined in Section 38-33-20(8).
- (4) "Health insurance plan" means a group health insurance policy or group health benefit plan offered by an insurer. It includes the State Health Plan, but does not otherwise include any health insurance plan offered in the individual market as defined in Section 38-71-670(11), any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer, as defined by Section 38-71-1330(17) of the 1976 Code.
- (5) "State Health Plan" means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.
- (B) A health insurance plan as defined in this section must provide coverage for the treatment of autism spectrum disorder. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan. With regards to a health insurance plan as defined in this section an insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual solely because the individual is diagnosed with autism spectrum disorder.
- (C) The coverage required pursuant to subsection (B) must not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health insurance plan, except as otherwise provided for in subsection (E). However, the coverage required pursuant to subsection (B) may be subject to other general exclusions and limitations of the health insurance plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.
- (D) The treatment plan required pursuant to subsection (B) must include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency, and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature. The health insurance plan may only request an updated treatment plan once every six months from the treating medical doctor to review

medical necessity, unless the health insurance plan and the treating medical doctor agree that a more frequent review is necessary due to emerging clinical circumstances.

(E) To be eligible for benefits and coverage under this section, an individual must be diagnosed with autistic spectrum disorder at age eight or younger. The benefits and coverage provided pursuant to this section must be provided to any eligible person under sixteen years of age. Coverage for behavioral therapy is subject to a fifty thousand dollar maximum benefit per year. Beginning one year after the effective date of this act, this maximum benefit shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the current Consumer Price Index, All Urban Consumers, as published by the United States Department of Labor's Bureau of Labor Statistics.

#### 38-71-290 Mental health coverage; definitions; treatment requirements; exceptions

- (A) As used in this section:
- (1) "Health insurance plan" means a health insurance policy or health benefit plan offered by an insurance issuer, including a qualified health benefit plan offered or administered by the State, or a subdivision or instrumentality of the State, that provides group health insurance coverage as defined by Section 38-71-840(12).
- (2) "Mental health condition" means the following psychiatric illnesses as defined by the "Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV)", and subsequent editions published by the American Psychiatric Association:
  - (a) Bipolar Disorder;
  - (b) Major Depressive Disorder;
  - (c) Obsessive Compulsive Disorder;
  - (d) Paranoid and Other Psychotic Disorder;
  - (e) Schizoaffective Disorder;
  - (f) Schizophrenia;
  - (g) Anxiety Disorder;
  - (h) Post-traumatic Stress Disorder; and
  - (i) Depression in childhood and adolescence.

- (3) "Rate, term, or condition" means lifetime or annual payment limits, deductibles, copayments, coinsurance and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of health insurance coverage that affects the insured.
  - (4) "Settings" means either emergency, outpatient, or inpatient care.
- (5) "Modalities" means therapeutic methods or agents including, without limitation, surgery or pharmaceuticals.
- (B) A health insurance plan must provide coverage for treatment of a mental health condition and may not establish a rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition in similar settings and treatment modalities. Any deductible or out-of-pocket limits required under a health insurance plan must be comprehensive for coverage of both mental health and physical health conditions.
- (C) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization if the managed care organization is in compliance with regulations promulgated by the director. The regulations promulgated by the director must ensure that timely and appropriate access to care is available, that the quantity, location, and specialty distribution of health care providers is adequate, and that administrative or clinical protocols do not prevent access to medically necessary treatment for the insured.
- (D) A health insurance plan complies with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms, and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions in similar settings and treatment modalities. The director may disapprove a plan that the director determines to be inconsistent with the purposes of this section.
- (E) To be eligible for coverage under this section for the treatment of mental illness, the treatment must be rendered by a licensed physician, licensed mental health professional, or certified mental health professional in a mental health facility that provides a program for the treatment of a mental health condition pursuant to a written treatment plan. A health insurance plan may require a mental health facility, licensed physician, or licensed or certified mental health professional to enter into a contract as a condition of providing benefits.
  - (F) The provisions of this section do not:
- (1) limit the provision of specialized medical services for individuals with mental health disorders:

- (2) supersede the provisions of federal law, federal or state Medicaid policy, or the terms and conditions imposed on a Medicaid waiver granted to the State for the provision of services to individuals with mental health disorders;
- (3) require a health insurance plan to provide rates, terms, or conditions for access to treatment for mental illness that are identical to rates, terms, or conditions for access to treatment for a physical condition;
  - (4) apply to a health insurance plan that is individually underwritten; or
- (5) apply to a health insurance plan provided to a small employer, as defined in Section 38-71-1330(18).
- (G) The provisions of this section apply where required regardless of the applicability of Section 38-71-880 regarding parity in the application of certain limits to mental health and substance use disorder benefits.

## 38-71-350 Required provision for continuation of coverage for handicapped and dependent children of policyholder.

An individual hospital or medical expense insurance policy, hospital service plan contract, or medical service plan contract delivered or issued for delivery in this State which provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age does not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of intellectual disability or physical handicap and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, so long as proof of the incapacity and dependency is furnished to the insurer by the policyholder or subscriber within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

#### 38-71-355 Dependent child; medically necessary leave of absence.

(A) As used in this section:

- (1) "Dependent child" means a covered person under a policy who:
- (a) is a dependent child, under the terms of the coverage, of an individual under the coverage; and
- (b) was enrolled in the coverage, on the basis of being a student at a postsecondary educational institution immediately before the first date of the medically necessary leave of absence involved.
  - (2) "Health insurance coverage" means as defined in Section 38-71-670(6).
- (3) "Health insurance issuer" or "issuer" means an entity that provides health insurance coverage in this State as defined in Section 38-71-670(7).
- (4) "Medically necessary leave of absence" means a leave of absence of a dependent child from a postsecondary educational institution, including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965, or any other change in enrollment of the child at such an institution, that:
  - (a) commences while the child is suffering from a serious illness or injury;
  - (b) is medically necessary; and
- (c) causes the child to lose student status for purposes of coverage under the terms of the policy.
- (B) This section applies to health insurance coverage offered by a health insurance issuer, that is delivered, issued for delivery, or renewed in this State and which provides health insurance coverage in the individual market.
- (C)(1) In the case of a dependent child, a health insurance issuer may not terminate health insurance coverage of the child due to a medically necessary leave of absence before the date that is the earlier of:
  - (a) one year after the first day of the medically necessary leave of absence; or
- (b) the date on which the coverage would otherwise terminate under the terms of the policy.
- (2) The provisions of this subsection apply to health insurance coverage offered by a health insurance issuer only if the issuer has received written certification by a treating physician of the dependent child that states the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.

- (D) Each health insurance issuer shall include with a notice regarding a requirement for certification of student status for coverage under the policy or coverage in a plain-language description of the terms of this section for continued coverage during medically necessary leaves of absence.
- (E) A dependent child whose benefits are continued under this section is entitled to the same benefits during the medically necessary leave of absence as if the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.
- (F) Coverage of the dependent child shall continue for the remainder of the period of the medically necessary leave of absence under the changed coverage in the same manner as it would have under the previous coverage in the case where:
- (1) a dependent child is in a period of health insurance coverage pursuant to a medically necessary leave of absence;
- (2) the manner in which the insured or dependent child is covered under the policy changes, whether through a change in health insurance coverage or health insurance issuer, or otherwise; and
  - (3) the coverage as changed continues to provide coverage of dependent children.

#### 38-71-360 Continuation of coverage for nonhandicapped dependent children.

An individual hospital, medical, or surgical expense incurred insurance policy, hospital service plan contract, or medical service plan contract, other than a limited classification policy, delivered or issued for delivery in this State which provides that coverage of a nonhandicapped dependent child terminates upon attainment of the limiting age for the child as specified in the policy or contract shall also contain a provision to the effect that upon the attainment of the limiting age the child is entitled to have issued to him, without evidence of insurability, upon application made to the insurer within thirty days following the attainment of the age, and upon payment of the appropriate premium, an individual policy of accident and health insurance. The policy shall provide the coverage then being issued by the insurer which is closest to, but not greater than, the terminated coverage. Any probationary or waiting period set forth in the policy must be considered as met to the extent coverage was in force under the prior policy. For purposes of this section, "limited classification policy" means an accident-only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

# 38-71-440 HMO's and health benefit plans offering medical eye care or vision care benefits; prohibited actions.

#### (A) As used in this section:

- (1) "Health benefit plan" means any public or private health plan implemented in this State that provides medical eye care or vision care benefits, or both, to covered persons including payments and reimbursements.
- (2) "Ophthalmologist" means a physician licensed pursuant to Title 40, Chapter 47 who practices in South Carolina and who specializes in the medical and surgical care of the eye and visual system and routine vision care.
- (3) "Optometrist" means a doctor of optometry licensed pursuant to Title 40, Chapter 37 who is engaged in the practice of optometry in South Carolina.
- (B) No health maintenance organization or health benefit plan which maintains or contracts with a network of ophthalmologists or optometrists, or both, to provide medical eye care or vision care benefits, or both, shall prohibit a participating optometrist from performing medical services within that optometrist's scope of practice set forth in Title 40, Chapter 37, in accordance with the terms of the health maintenance organization or health benefit plan and in accordance with subsections (C) and (I).
- (C) No health maintenance organization or health benefit plan which maintains or contracts with a network of ophthalmologists or optometrists, or both, to provide medical eye care or vision care benefits, or both, excepting all self-funded health benefit plans as defined under the Federal Employee Retirement Income Security Act (ERISA) of 1974, shall discriminate against optometry, as a class, or ophthalmology, as a class, with respect to the terms, conditions, privileges, and opportunity of participation or compensation for the same eye care services provided in this section.
- (D) No health benefit plan or health maintenance organization shall impose on optometry, as a class, any condition or restriction which is not necessary for the delivery of services or materials, or both, in accordance with and subject to Chapter 37, Title 40.
- (E) Any health maintenance organization or health benefit plan may contract for vision care benefits or medical eye care benefits, or both. A health maintenance organization or health benefit plan may contract for surgery only services with ophthalmologists. A health maintenance

organization or health benefit plan must be authorized to contract with optometrists and ophthalmologists as either individual panelists or network panelists.

- (F) Nothing in this section may be construed to limit, expand, or otherwise affect the scope of practice of optometrists and therapeutically certified optometrists as provided for in Chapter 37, Title 40.
- (G) Nothing in this section may be construed to preclude a covered person from receiving emergency medical eye care or to preclude a primary care physician from providing treatment for covered services in accordance with the terms of a health maintenance organization or health benefit plan.
  - (H) Nothing in this section may be construed to mandate coverage of any service.
- (I) Nothing in this plan may be construed to prohibit a health maintenance organization or health benefit plan from professionally credentialing and evaluating all individual optometrists or ophthalmologists within a network or plan in a nondiscriminatory manner. Nothing in this section may be construed to prohibit any health maintenance organization or health benefit plan from limiting the number of optometrists or ophthalmologists in a nondiscriminatory manner or to prohibit a health maintenance organization or health benefit plan from negotiating individually with optometrists or ophthalmologists for individual rates and eye care services in a nondiscriminatory manner.
- (J) Any person aggrieved by a violation of this section may file a complaint with the Department of Insurance. After notice to the health maintenance organization or health benefit plan and an opportunity for it to submit a written response to the complaint, the director of the department may make a written determination regarding the complaint. Any party aggrieved by the director's determination is entitled to administrative and judicial review pursuant to Article 3, Chapter 23, Title 1. The director or the administrative law judge, if a hearing before the Administrative Law Judge Division is requested, may impose sanctions that are authorized under current insurance laws if a violation of this section is found to have occurred.

# 38-71-737 Requirement of coverage for psychiatric conditions in group health insurance policies; "psychiatric conditions" defined.

(A) An offer to sell a group health insurance policy must include an offer of an optional rider or endorsement to provide benefits for psychiatric conditions as defined in this section. The offer of coverage may contain provisions prescribing different benefits for psychiatric conditions

and physical conditions with respect to any deductible amount, coinsurance provision, or contract term affecting benefit determinations based upon use or nonuse of preferred providers.

- (B) The offer of an optional rider or endorsement for a group health insurance policy must provide minimum benefits for psychiatric conditions not less than two thousand dollars for each member for each benefit year with a lifetime maximum benefit of ten thousand dollars. In the case of group health insurance coverage, as defined in Section 38-71-840, the requirements of Section 38-71-880 regarding parity in the application of certain limits to mental health benefits shall apply to those benefits defined as mental health benefits in Section 38-71-880(E). However, if group health insurance coverage is exempted from the requirements of Section 38-71-880, then the requirements of this provision shall apply. In addition, for group health insurance coverage, the requirements of this provision shall apply to benefits for psychiatric conditions which are not considered mental health benefits.
- (C) This section does not prohibit an insurer from issuing or continuing to issue a health insurance policy which provides benefits greater than the minimum benefits required by this section or benefits generally more favorable to the insured than those required by this section.
- (D) As used in this section, "psychiatric conditions" means those mental and nervous conditions, drug and substance addiction or abuse, alcoholism, or other conditions that are defined, described, or classified as psychiatric disorders or conditions in the most current publication of the American Psychiatric Association entitled "The Diagnostic and Statistical Manual of Mental Disorders".

#### 38-71-770 Mandatory continuation privileges.

A group policy issued for delivery or renewed in this State which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred basis must provide that an employee or member who has been insured continuously under the group policy for at least six months whose insurance under the group policy has been terminated for any reason other than nonpayment of the required contribution is entitled to continue coverage under the group policy for the fractional policy month remaining at termination plus six additional policy months. A group policy is considered to be a successor policy within the meaning of this section if the effective date of the coverage provided by it is sixty-two days or less after the date of termination of coverage of the prior carrier. The employee or member is not entitled to have his coverage continued if the employee or member was entitled under federal law to continuation of his coverage for a period of greater duration than provided by this section. Continuation of coverage is subject to the group policy or a

successor policy remaining in force and the employee paying the entire group premium, including any portion usually paid by the former employer, before the date each month that the group policy month begins. Policies which provide benefits for other than hospital, surgical, major medical, or which provide benefits for specific diseases or accidental injuries only are not affected by this section.

A notification of the privilege to continue coverage after termination must be included in each certificate of coverage. In addition, the employer shall clearly and meaningfully advise an employee upon termination of the right to continue insurance and shall advise the employee of the amount of premium required and of the employee's responsibility to pay the premium each month before the date that the policy month begins. An employee is not entitled to continue coverage under the group if eligible for other group coverage which provides similar benefits nor if the person is eligible for medicare benefits provided by Title XVIII of the United States Social Security Act or of any successor acts. Any benefits, except extended benefits payable by the policy during the period of continuation, are considered secondary to benefits under any other group health policy that is in force on a person insured through this continuation privilege.

### 38-71-780 Required provision for continuation of coverage for handicapped and dependent children.

A group hospital or medical expense insurance policy, hospital service plan contract, or medical service plan contract delivered or issued for delivery in this State which provides that coverage of a dependent child of an employee or other member of the coverage group terminates upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age does not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of intellectual disability or physical handicap, and (b) chiefly dependent upon the employee or member for support and maintenance, as long as proof of the incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

38-71-785 Dependent child; medically necessary leave of absence.

- (A) As used in this section:
  - (1) "Dependent child" means a beneficiary under a policy or certificate of coverage who:
- (a) is a dependent child, under the terms of the coverage, of a participant or beneficiary under the coverage; and
- (b) was enrolled in the coverage, on the basis of being a student at a postsecondary educational institution immediately before the first date of the medically necessary leave of absence involved.
  - (2) "Health insurance coverage" means as defined in Section 38-71-840(14).
- (3) "Health insurance issuer" or "issuer" means an entity that provides health insurance coverage in this State as defined in Section 38-71-840(16).
- (4) "Medically necessary leave of absence" means a leave of absence of a dependent child from a postsecondary educational institution, including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965, or any other change in enrollment of the child at such an institution, that:
  - (a) commences while the child is suffering from a serious illness or injury;
  - (b) is medically necessary; and
- (c) causes the child to lose student status for purposes of coverage under the terms of the policy or certificate of coverage.
- (5) "State health plan" means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.
- (B) This section applies to health insurance coverage offered by a health insurance issuer, including the state health plan, that is delivered, issued for delivery, or renewed in this State and which provides health insurance coverage in the group market.
- (C)(1) In the case of a dependent child, a health insurance issuer may not terminate health insurance coverage of the child due to a medically necessary leave of absence before the date that is the earlier of:
  - (a) one year after the first day of the medically necessary leave of absence; or
- (b) the date on which the coverage would otherwise terminate under the terms of the policy or certificate of coverage.

- (2) The provisions of this subsection apply to health insurance coverage offered by a health insurance issuer only if the issuer has received written certification by a treating physician of the dependent child that states the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is medically necessary.
- (D) Each health insurance issuer shall include with a notice regarding a requirement for certification of student status for coverage under the policy or coverage in a plain-language description of the terms of this section for continued coverage during medically necessary leaves of absence.
- (E) A dependent child whose benefits are continued under this section is entitled to the same benefits during the medically necessary leave of absence as if the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.
- (F) Coverage of the dependent child shall continue for the remainder of the period of the medically necessary leave of absence under the changed coverage in the same manner as it would have under the previous coverage in the case where:
- (1) a dependent child is in a period of health insurance coverage pursuant to a medically necessary leave of absence;
- (2) the manner in which the participant or beneficiary is covered under the policy or certificate of coverage changes, whether through a change in health insurance coverage or health insurance issuer, a change from self-insured coverage to health insurance coverage, or otherwise; and
  - (3) the coverage as changed continues to provide coverage of dependent children.

### 38-71-880 Medical and surgical benefits and mental health or substance use disorder benefits; aggregate lifetime limits.

(A)(1) In the case of health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits:

- (a) if the coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits;
- (b) if the coverage includes an aggregate lifetime limit, also referred to in this item as the "applicable lifetime limit", on substantially all medical and surgical benefits, the coverage must either:
- (i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of the limit between the medical and surgical benefits and mental health and substance use disorder benefits; or
- (ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit;
- (c) in the case of coverage that is not described in subitem (a) or (b) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the director or his designee may promulgate regulations under which subitem (b) is applied to the coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to the categories.
- (2) In the case of health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits:
- (a) if the coverage does not include an annual limit on substantially all medical and surgical benefits, the coverage may not impose any annual limit on mental health or substance use disorder benefits;
- (b) if the coverage includes an annual limit on substantially all medical and surgical benefits, referred to as the "applicable annual limit", the coverage must either:
- (i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or
- (ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit;

- (c) in the case of coverage that is not described in subitem (a) or (b) and that includes no or different annual limits on different categories of medical and surgical benefits, the director or his designee may promulgate regulations under which subitem (b) is applied to the coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to the categories.
- (3) In the case of a group health plan, or health insurance coverage offered in connection with a plan, that provides both medical and surgical benefits and mental health or substance use disorder benefits, the plan or coverage must ensure that:
- (a) the financial requirements applicable to the mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan or coverage and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
- (b) the treatment of limitations applicable to the mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan or coverage and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.
- (4) In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage must provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.
- (B) To the extent consistent with Section 38-71-737 and another applicable state law, nothing in this section may be construed:
- (1) as requiring health insurance coverage offered in connection with a group health plan to provide any mental health or substance use disorder benefits; or
- (2) in the case of a group health plan or health insurance coverage offered in connection with a plan that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to benefits under the plan or coverage, except as provided in subsection (A).
- (C)(1) This section does not apply to a group health insurance coverage offered in connection with a group health plan for any plan year of a small employer.

- (2) For purposes of this subsection, "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.
  - (3) For purposes of this subsection:
- (a) All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 are treated as one employer.
- (b) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.
- (c) A reference in this subsection to an employer includes a reference to any predecessor of the employer.
- (4) This section does not apply with respect to health insurance coverage offered in connection with a group health plan if the application of this section to this coverage results in an increase in the actual total cost for the coverage of at least two percent in the case of the first plan year or at least one percent in the case of a subsequent plan year. Determinations as to increases in actual total costs under a plan or coverage for purposes of this subsection must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. Determinations must be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, must be maintained by the group health plan and the health insurance issuer for a period of six years.
- (5) When a group health insurance coverage offered in connection with a group health plan that qualifies for exemption pursuant to the provisions of item (2), the plan or coverage must continue to apply the requirements of applicable state law, including Sections 38-71-290 and 38-71-737, where required.
- (D) In the case of health insurance coverage offered in connection with a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section are applied separately with respect to each option.
  - (E) For purposes of this section:
- (1) "Aggregate lifetime limit" means, with respect to benefits under health insurance coverage, a dollar limitation on the total amount that may be paid with respect to the benefits under the health insurance coverage with respect to an individual or other coverage unit.

- (2) "Annual limit" means, with respect to benefits under health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to the benefits in a twelve-month period under the health insurance coverage with respect to an individual or other coverage unit.
- (3) "Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and annual limit subject to subsections (A)(3)(a) and (A)(3)(b).
- (4) "Medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.
- (5) "Mental health benefits" means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable federal and state law.
- (6) "Predominant" means a financial requirement or treatment limit that is the most common or frequent of the type of requirement or limit.
- (7) "Substance use disorder benefits" means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law.
- (8) "Treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

# 38-71-1530 Screening; initial intervention; role of managed care organization; payments to providers.

- (A) A patient who presents to an emergency department, by the Federal Social Security Act, must be screened to determine whether an emergency medical condition exists. This evaluation may include, but is not limited to, diagnostic testing to assess the extent of the condition, sickness, or injury and radiographic procedures and interpretation.
- (B) Appropriate intervention must be initiated by medical personnel to stabilize any emergency medical condition before requesting authorization for the treatment by a managed care organization.
- (C) A managed care organization shall inform its insureds, enrollees, patients, and affiliated providers about all policies related to emergency medical care access, coverage, payment, and grievance procedures. It is the ultimate responsibility of the managed care organization to

inform any contracted third party administrator, independent contractor, or primary care provider about the emergency medical care provisions contained in this subsection.

- (D) A managed care organization which includes emergency medical care services as part of its policy or contract shall provide coverage and shall subsequently pay providers for emergency medical care services provided to an insured, enrollee, or patient who presents an emergency medical condition. This subsection must not be construed to require coverage for illnesses, diseases, equipment, supplies, or procedures or treatments which are not otherwise covered under the terms of the insured's policy or contract.
- (E) A managed care organization may not retrospectively deny or reduce payments to providers for emergency medical care of an insured, enrollee, or patient even if it is determined that the emergency medical condition initially presented is later identified through screening not to be an actual emergency, except in these cases:
  - (1) material misrepresentation, fraud, omission, or clerical error;
- (2) a payment reduction due to applicable co-payments, co-insurance, or deductibles which may be the responsibility of the insured;
- (3) cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.